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Veröffentlichungsversion / Published Version
Zeitschriftenartikel / journal article

Empfohlene Zitierung / Suggested Citation:
Beserra, P. J. F., Nóbrega, M. M. L. d., Nogueira, J. d. A., & Bittencourt, G. K. G. D. (2015). Production of women on vulnerability to HIV/aids: an integrative review of the literature. *Revista de Pesquisa: Cuidado é Fundamental Online*, *7*(Supl.), 105-118. https://doi.org/10.9789/2175-5361.2015.v7i5.105-118

ISSN 2175-5361

Federal University of Rio de Janeiro State

Journal of Research Fundamental Care Online

ISSN 2175-5361
DOI: 10.9789/2175-5361

INTEGRATIVE REVIEW OF THE LITERATURE

Produção sobre vulnerabilidades de mulheres ao HIV/aids: uma revisão integrativa da literatura

Production of women on vulnerability to HIV / aids: an integrative review of the literature

Producción de vulnerabilidad de las mujeres frente al HIV/sida: una revisión integradora de la literatura

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ABSTRACT

Objective: identifying strategies of care developed with children in mental distress and describing the concept of families and professionals about these care practices. **Method:** a qualitative study conducted in July and August 2013 with professionals and families of children enrolled in CAPSi in Campina Grande. The material was analyzed by means of the proposed of Bardin, from which emerged the following category: The care strategies used in CAPSinho (little CAPS). **Result:** care practices developed were: the play activities of social integration, sensory stimulation, play group, among others. Family members and professionals emphasized the positive aspects of strategies developed in the service; however, they mentioned as a barrier the absence of some professionals. **Conclusion:** although it has been noticed changes in the behavior of children, the development of these practices of care requires a planning and monitoring geared to the needs of children, making it essential working with a multidisciplinary team. **Descriptors:** Child Care; Mental Health; Health Service.

RESUMO

Objetivo: identificar estratégias de cuidado desenvolvidas junto às crianças em sofrimento mental e descrever a concepção dos familiares e profissionais sobre essas práticas de cuidados. **Método:** pesquisa qualitativa realizada em julho e agosto de 2013 com profissionais e familiares das crianças atendidas no CAPSi em Campina Grande. O material foi analisado por meio da proposta de Bardin, de onde emergiu a seguinte categoria: As estratégias de cuidado utilizados no CAPSinho. **Resultado:** as práticas de cuidado desenvolvidas foram: as atividades lúdicas de integração social, estímulo sensorial, grupo de brincar, dentre outras. Os familiares e profissionais enfatizaram aspectos positivos das estratégias desenvolvidas no serviço, no entanto, referiram como obstáculo à ausência de alguns profissionais. **Conclusão:** embora se tenha observado mudanças no comportamento das crianças, o desenvolvimento dessas práticas de cuidado requer um planejamento e acompanhamento voltados para as necessidades das crianças, tornando imprescindível o trabalho com equipe multidisciplinar. **Descritores:** Cuidado da Criança; Saúde Mental; Serviço de Saúde.

RESUMEN

Objetivo: identificar las estrategias de atención desarrolladas con los niños en la angustia mental y describir el concepto de las familias y los profesionales acerca de estas prácticas de atención. **Método:** un estudio cualitativo realizado en julio y agosto de 2013 con los profesionales y las familias de los niños matriculados en CAPSi en Campina Grande. El material fue analizado mediante la propuesta de Bardin, de la que surgió la siguiente categoría: Las estrategias de atención utilizados en CAPSito. **Resultado:** se desarrollaron las siguientes prácticas de cuidado: las actividades de juego de la integración social, la estimulación sensorial, el juego en grupo, entre otras. Los familiares y profesionales hicieron hincapié en los aspectos positivos de las estrategias desarrolladas en servicio, sin embargo, se mencionaron como una barrera la ausencia de algunos profesionales. **Conclusión:** a pesar de que ha observado cambios en el comportamiento de los niños, el desarrollo de estas prácticas de atención requiere una cuidadosa planificación y monitoreo orientados a las necesidades de los niños, por lo que es esencial trabajar con un equipo multidisciplinario. **Descriptores:** Cuidado de Niños; Salud Mental; Servicio de Salud.

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INTRODUCTION

In the early 1990s, with the growing number of AIDS cases in the female population in the world and in Brazil, the issue of feminization of the epidemic emerges as a discussion point for activists, researchers and technicians in the health sector.

From this decade, in Brazil, there was a transition from the epidemiologic profile of AIDS, resulting in heterosexualization, feminization, impoverishment and internalization of the epidemic. Thus, it appears that the sex ratio, which was of 25 men for each woman in 1991, it passed to 2 men for each woman in 2000, showing a trend of feminization of HIV/AIDS[1]; the pandemic tending towards gender parity, determining a profound impact on women's health around the world[2].

This epidemiological transition characterizes a specific group that deserves expert attention of health services. To this end, the Special Secretariat of Policies for Women and the Ministry of Health, through the Department of Sexually Transmitted Diseases and AIDS and Technical Area of Women's Health, presented to the institutions working in the field of human rights, sexual rights and reproductive rights of Brazilian women the Integrated Plan to Combat the Feminization of the Epidemic of AIDS and other STDs, whose purpose is to guide the deployment and implementation of actions to promote health and rights, of the sexual and reproductive area, at federal, state and municipal level. To do so, set up intersectoral strategies to increase access to inputs and to prevention, diagnosis and treatment of sexually transmitted diseases and AIDS among women from different Brazilian regions, being important that in every state, municipality, community, be mapped the specificities of women for whom the actions are prioritized[3].

It is known that STDs are often asymptomatic, especially among women, hindering early diagnosis, thus, facilitating the occurrence of complications such as infertility and ectopic pregnancy. Several factors, in addition to the biological characteristics, contribute to that women being more susceptible to STDs. With the evolution of the HIV epidemic, these diseases have assumed a greater role in facilitating the spread of the virus, the proper management of these illnesses, for the prevention of HIV infection is required[3].

Paying attention to the complexity of the AIDS epidemic in women means putting into focus the gender inequality, in interaction with poverty, racism, violence, stigma and difficulty in negotiating safe sex; increasing the vulnerabilities of adolescent, young, adult and elderly women to STD/HIV/AIDS. This reinforces the need of examining the factors those contribute to the vulnerability of women to HIV infection.

The construction of the conceptual framework of vulnerability in health is relatively recent and is closely related to the effort to overcome the preventive practices supported the concept of risk[3]. Vulnerability is conceptualized as the movement to consider the chance of exposing people to illness as a result of a number of aspects not only individual but also collective and contextual. The different situations of vulnerability of the subjects

can be individualized by the recognition of three interrelated components - individual, social and institutional or programmatic [6].

Articulated, the three constituent components of an approach supported in the conceptual framework of vulnerability prioritize an inseparable approach of a "comprehensive approach" to know that the "parties" deal with it every day; professionals make sense within a whole that makes apprehensible to function as axes articulators in educational practices in health-care[3]. In this context, which necessitates research on issues affecting women in the context of HIV/AIDS is believed, considering the different factors that contribute to the existence of vulnerabilities to HIV/AIDS to think of any possibilities of health practices to cover the needs of this population.

Thus, this study was developed; whose goal is to know, based on a literature review, the associated vulnerabilities of women to HIV/AIDS factors.

METHOD

It was an integrative literature review based on the following steps: problem formulation, data collection, evaluation of data collected, analysis and interpretation of data and presentation of results[7].

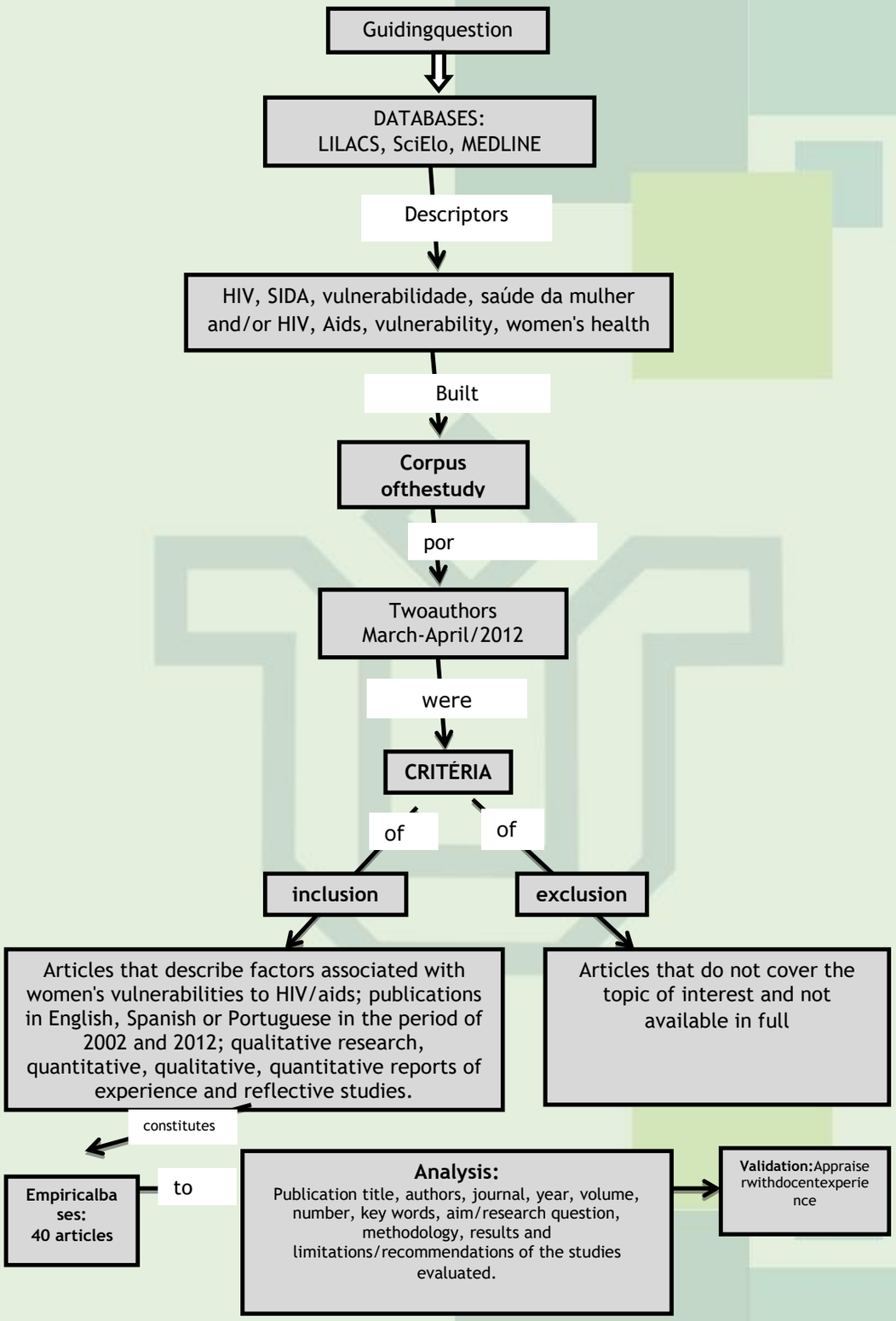
The formulation of the problem is characterized by the research question: “What factors associated with vulnerability of women to HIV/AIDS?” To collect the data there were set the databases: Latin American and Caribbean Literature - LILACS; Electronic Library of Brazilian Scientific Journals - SCIELO Brazil and International Literature- MEDLINE. There were used the descriptors HIV, SIDA, vulnerability; women's health and/or HIV; AIDS. There were established themselves as inclusion criteria: articles, theses and dissertations to describe factors associated with women's vulnerabilities to HIV/AIDS, national and international in English, Spanish or Portuguese; publications in the period between 2002 and 2012, qualitative research, quantitative, qualitative and quantitative, experience reports and reflective studies. Exclusion criteria were articles that did not cover the topic of interest, not available online and presented no factors associated with women's vulnerabilities to HIV/AIDS.

There was developed a tool to record information in order to organize them according to the guiding question of the study which comprised identification data with the items (title, author, journal, year, volume, number, descriptors); goal/question research studies, methodology, and, finally, the results and the limitations/recommendations of the studies assessed. The validation was made by an appraiser with teaching experience.

Name of the authors, the study objective, methodology and main results: From the information collection instrument data, a summary table which included the following aspects was elaborated. From the data synthesis, analysis was performed and the results of studies made up thematic categories according to the associated vulnerabilities of women to HIV/AIDS identified in the analyzed studies factors. The presentation of results was through pictures for the exhibition of the same integrating the results of the studies

reviewed. It is noted that in this study, commitment to the ethical aspects involved the citation of authors of the studies analyzed.

Figure 1- Flow chart of the methodological description of the study. João Pessoa, 2013.



Source: Prepared by the authors, 2013.

RESULTS E DISCUSSION

There were identified 310 studies on the basis of Latin American and Caribbean Literature databases - LILACS; Electronic Library of Brazilian Scientific Journals - SCIELO Brazil and International Literature - MEDLINE. Of these, 109 were available in full. A crossing of the articles was conducted in the databases in search of repetitions and 38 repetitions were identified, thus remaining 71 studies, however, 14 of them were available only in abstract form, leaving 57 studies. The 57 selected studies were read in full and were evaluated in relation to the associated vulnerabilities of women to HIV/AIDS, of whom 17 were excluded because they were factors not directly related to the theme studied and, thus, 40 studies in the sample of this review integrative.

Of the 40 studies selected in this review, 36 of them, representing 91,2% of the sample, are derived from original research studies. Regarding the type of study, 19 of them are descriptive, the 09 studies are exploratory, and 20 studies have a qualitative approach. Five studies are outlined as transversal and other studies involve systematic review, reporting experience and sample survey. It was found that 06 studies were published in the journal DST - Brazilian Journal of Sexually Transmitted Diseases, 06 studies were published in the journal Health and Society, 06 studies were published in the journal Public Health Magazine and the year of publication was the prevalent of 2010 with 09 studies.

Table 1 presents the major factors associated with vulnerability of women to HIV / AIDS identified in the studies analyzed according to frequency they were mentioned.

Table 1 - Factors associated with women's vulnerability to HIV / AIDS. João Pessoa, 2013.

Factors associated with women's vulnerabilities to HIV/AIDS	Main results of the studies	Authors
Absence of condoms in stable relationships	Submission and difficulty in negotiating the use of condoms during sexual intercourse and in stable relationships.	Ribeiro et al[8]; Carneiro et al[9]; López[10]; Rangel[11]; Guedes et al[12]; Sousa et al[13]; Souza[14]; Silveira et al[15]
	Difficulty of the use of the female condom in women with positive serology.	Preussler, Dezoti, Rubim[16]
	Relationship between information about the disease and little awareness of condom use.	Silva[17]
	Use of condoms as a barrier method with casual partners and not with stable partner.	Silva, Lopes, Vargens[18]; Morales, Barreda[19]
	Women living with HIV/AIDS presented early sex life early and fewer adherences to condom use.	Santos et al[20]
	Condom as a contraceptive method and not as a barrier.	Figueiredo, Terenzi[21]; Nascimento[22]; Maliska et al[23]
	Confidence in partner, luck and faith in God are conditions of immunity.	Nascimento et al[24]
	Women rule the sexual intercourse only in choosing the form of sex and not in the protection of their bodies.	Borba, Clapis[25]
	Women have lower rate of sexual activity, sexual life begins later, have fewer casual	Pascom, Szwarcwald[26]

Factors associated with women's vulnerabilities to HIV/AIDS	Main results of the studies	Authors
	partners than men, but use less the condom.	
	Women's difficulty in requiring the condom and the shame of disappointing their partner.	Silva, Vargens[27]
	Women use condoms regularly with customers, but with stable partners the use is irregular, especially among married women.	Barrientos et al[28]
Gender and power relations	Young women monogamous attributed to male sex as a physical need and feminine as proof of love; Sexual attitudes and differentiated social to be performed between men and women; for the female gender relationship stability is HIV prevention; the man has sexual active role and the woman is passive.	Ribeiro, Silva, Saldanha[29]; Preussler, Dezoti, Rubim[16]; Rangel[11]; Figueiredo, Terenzi[21]; Saldanha[30]; Nascimento et al[24]; Franco[31]; Maia et al[32];Silva, D'Oliveira, Mesquita[33] Silva, Lopes, Vargens[18]; Morales, Barreda[19]
	In the family context, for women are addressed themes of virginity and pregnancy and for men sexual relationship issues and AIDS.	Ribeiro et al[8]
	Cultural norms of genres are the mode of experiencing the sexuality, the choices of partners and the possibility of negotiating condom use causing female subordination.	López[10]; Silva[17]; Ribeiro et al[8]; Rangel[11]; Cechim et al[34]; Franco[31]; Saldanha[30]; Lopes et al[44]; Maliska et al[23]; Escobar et al[35]; Morales,Barreda[19]; Torres et al[36]; Rosete et al[37]
	Women who require condom use are promiscuous, unreliable and belong to the risk group; Condom use brings the idea of deviant sexual behaviour of monogamous model.	Nascimento et al[24]; Nascimento[22]; Maliska et al[23]; Maia et al[32]; Pascom, Szwarcwald[26]; Silva, Vargens[27]; Rosete et al[37]; Passador[38]
	Culturally, the traditional gender relations ideology makes a minor position of women to negotiate safer sex practices with their partners.	Albuquerque et al[39]; Borba, Clapis[25]; Venereo, et al[40]
Female submission in emotional relationships	Love and fidelity in the affective relations have been marked by the subordination to male desire; Affective dependence, lack and romanticism are factors of female submission; the man determines the sexual behaviours and impose your requirements;	Preussler, Dezoti, Rubim[16]; Silva, Lopes, Vargens[18]; Figueiredo, Terenzi[21];
	Women consider the relationship with partner believing in its exclusivity as sexual partner; not identify the partner as risk for HIV infection; The longer the time of coexistence, the greater the sense of trust and abandonment of protective measures;	Guedes et al[12]; Silva[17]; Gir et al[41]; Carneiro et al[9]
	Married women do not feel vulnerable to HIV even in the face of suspicion of her husband's extramarital relationships.	Silva, Vargens[27]
Racism and violence against women	The black woman suffers physical and symbolic violence on their bodies based on hipererotização, the stigma of a body taken and seen as passive.	López[9]; Riscado, Oliveira, Brito[42]; Cechimet al[34]

Factors associated with women's vulnerabilities to HIV/AIDS	Main results of the studies	Authors
	The abrupt disruption of everyday life, the fragmentation of family and social networks, the condition of gender, race and, in some women, sexual violence, difficulty of access to health services, in addition to the lack of prevention are related to greater vulnerability to STI/HIV/AIDS.	Riscado, Oliveira, Brito[42]; Torres et al[36]
	Women sex workers have early sexual initiation, submit to the prostitution resulting in poor living conditions; aggressive parents and alcoholics are domestic violence.	Borba, Clapis[25]
	Women submit to forced sex; the violation of economic and cultural obligations to keep unwanted sexual relations by increasing the risk of contracting HIV.	Escobar et al[35]
Drugs' use	Women who have unsafe behaviors such as the multiplicity of partners and share drugs intravenously do not identify as risk for HIV infection.	Gir et al[41]
	The use of drugs, the beginning of sexual life early, the largest proportion of history of STD and sexual violence among women living with HIV/AIDS are factors that showed significant differences statistically to vulnerability to HIV/AIDS.	Santos et al[20]
	Women drug users maintain affective relationships and unprotected sex with drug users; the use of alcohol and drugs increases the vulnerability of women to HIV secondarily.	Oliveira, Paiva[43]; Silveira et al[15]; Lopes Buchalla, Ayres[44]; Venereo et al[39]
	Sale of the body for the acquisition of drugs increases the likelihood of contracting Aids; This kind of transaction occurs without adoption of safe sex.	Oliveira, Paiva[43]; Gir et al[40]
	Difficulty of use of condoms is common among women who use drugs because of the trust in friends and partners, coupled with the desire to pleasure and the belief that man is responsible for preventive care.	Oliveira, Paiva[43]; Silva, D'Oliveira, Mesquita[32]
Socioeconomic situation	Women with less access to education and income are dependent on men.	Lopes Buchalla, Ayres[44]; Maliska et al[23];
	Less bargaining power of condom use among less educated women with low socioeconomic status and conditions of economic dependence.	Souza[14]; Carneiro et al[9]; Barrientos et al[28]
	Women are barriers to negotiate protected sex, regardless of their level of education, income, financial autonomy, the trajectories or lifestyle of the partner.	Lopes Buchalla, Ayres[44]
	Female sexuality is related to the behaviour of partners and the socio-economic situation, reinforcing its condition of oppression.	Cechim et al[34]; Nascimento[22]; Maia et al[32]; Escobar et al[35]

The absence of condoms in steady relationships is related to the difficulty in negotiating condom use with the concepts of fidelity, stability, steady partner, monogamy and information about the disease, giving the feeling of safe sex and resulting in the decision not to use. Studies show that condom use is relatively low and not using condoms among women in a stable relationship was attributed to the negative partner. The first determinant for condom use is trust in the partner, given by union type. Consistent condom use was more frequent in future partnerships[14]. The fact that women have sex without condom use by partners, can partly be explained by the intimacy and trust built over the years together, and even by ease acquired by the couple[12].The use of the female condom

provides autonomy and freedom of choice, whether or not women know their HIV status, its injury and the need to protect themselves are failing to use the female condom for failure to introject this practice in their behavior or by little or no information on STDs/ AIDS and little awareness of condom use[16,18].

Moreover, the condom as a contraceptive method arises, never as a barrier to disease and suggest the use of condoms, not for contraception, can lead to distrust her husband of being betrayed or feel discredited by his wife in their extramarital attitudes[22].The negotiation with the partner about condom use is often difficult, and sometimes requires the claim that security is to prevent an unwanted pregnancy[13].

In gender relations and power male and female roles culturally established substantially interfere in decisions about prevention of HIV/AIDS chosen by 32 individuals. Reveal, on the one hand, power inequalities based on gender and on the other, the status of trust and complicity regular partners. The stability of the affective-sexual relationship is seen as a safe passport to avoid infection, both for men and for women 44. This situation is understood by the cultural norms of gender, guiding the way to experience sexuality, choice of partners, and the ability to negotiate the use of condoms. Belief that, by having greater knowledge, man would be responsible for preventive care or reliance on fidelity of the stable partner.[33]

Relations between men and women, the woman always remained on paper acceptance, subordination, triggering different sexual and social attitudes to be performed for men and women[16]. The man is the provider and has active sexual role; women have home care and is passive sexual[20]. For these women AIDS is a distant evil, is near, not theirs, it belongs to them is legitimized by being "God's work" or being itself the role of wife. Sex is seen as more of a domestic bond woman, but it is, above all, a desire of the husband. It is proper to man having "sexual needs" and woman's duty to satisfy them mainly being provided by the partner and wife. Suggest condom use, not for contraception may cause distrust her husband of being betrayed or feel discredited by his wife in their extramarital attitudes. Trust in the partner, luck and faith in God, ultimately, generate conditions of almost absolute immunity [21].

It was shown up situations of vulnerability as a consequence of naturalization, particularly as regards the relations between the genders. The vast majority of women do not realize vulnerable to HIV. Especially those who are in a stable relationship, where they believe there is love, respect and trust between the couple. As a tragic consequence, are victims of partner infection.[30]

It is striking yet feminine submission in affective relationships as a result of asymmetrical gender relations and power. Historically oppressed, subjugated, women have had very limited power in the field of emotional-sexual relationships. Therefore, consciously or unconsciously, at some point the relationship, choose to submit to the choices of partner.

The gender inequality is the result of a historical process that reveals a woman's submission in relation to man. Women were shifted decision-making power in public or private life with the everyday, domestic and sexual violence was part of their reality. Women have less freedom in their sexual life and have less decision-making power about protected sex[18]. The man sends, manages behaviors, impose the needs[21]. Tying is experienced through sexuality, sexual satisfaction, partner communication/lack of dialogue

with the partner and practices of infidelity[19]. Thus, these unequal relations translate into increased vulnerability for women, contributing to the increase in numbers. Human relationships are supported by pillars that create a dependency relationship between the people involved, due to the exchange of feelings contained in relations.

Marriage is highlighted by women as a protective factor to the disease. The marriage for women is love, loyalty, respect, trust and complicity. There is a presumption that, by entering these values in everyday life, men and women are protected from the risk of infection. Marriage creates a romantic and eternal view of love between the couple, and this can make you abandon the use of condoms and believe they are truly protected against AIDS[18].

The woman relies on her monogamy, but this behavior is being practiced by the couple because of a security does not guarantee the other, although many women think so. Monogamy is considered a protective factor against STDs/HIV/AIDS, since it decreases the exposure to a variety of partners, reducing the chances of contamination. The longer the duration of cohabitation, the greater is the intimacy to an open protection against STDs trading, as one can also think that the bigger this time, the greater the feeling of confidence and abandonment of protective measures [12].

Racism and violence against women appear strongly in the studies. History has shown that black women are discriminated against triply: being a woman, being black and, consequently, for their class 41 (low socioeconomic status, either with regard to education, the individual or family per capita monthly income or condition of property)[44].

These women suffer violence when they suffer any kind of action that causes her harm or physical, sexual, psychological, and economical and can happen in both the private and the public environment suffering. Physical violence is defined as one that causes the victim harm to their body, characterized by kicks, slaps, punches, pinches, burns, choking, wounds, bodily injury and assault with weapons. Psychological violence is one that causes damage to self-esteem, identity of the woman. This type of violence disqualifies the woman, or the woman starts to suffer in their everyday insults, shouting, swearing, humiliation, threats, and emotional blackmail. Sexual violence is any action that forces the woman to have sex without the expression of his will through use of physical force, coercion and psychological intimidation, which will somehow discredit the woman and consequently contribute to their low esteem.

In this sense, violence is seen as cruel and perverse way that contributes to the depreciation or devaluation of the dignity of the woman, objectivizing it. This is therefore a perverse form of male power and control, who seizes the freedom and dignity of the woman and turns it into a mere object of satisfaction and desire of man[42]. Forced sex in all its forms, ranging from the violation of economic and cultural obligations to keep unwanted sex increases the risk of micro lesions and therefore of contracting HIV or other sexually transmitted infections[35].

The hyperiotized image of black women and the double oppression of gender and race appear as axis for a critical look at the spread of HIV/AIDS in this group. The black woman is modeled according to denounce the black militants, the stigma of a body and had seen as a liability, on which can be exercised sexual violence[10].

The use of injectable drugs through shared materials is responsible for many cases of HIV infection. The situation is alarming as these numbers are on the rise, and this route of

transmission has been held responsible for the continuous changing profile of the epidemic. Moreover, the rapid expansion of the use of drugs, such as crack, and its association with prostitution and violence, are additional factors of vulnerability of people to acquire STD/ AIDS. The current landscape of drug use shows that women still underestimate consumption by these partners, because it does not see them as a risk factor for HIV acquisition. As for alcohol, this is not seen as a risk factor itself, but as a condition or a marker that can leave vulnerable to other possible risk factors to people[41].

The trend among drug users, to maintain affective and sexual relationships, too, men drug users. Sale body by the drug with the risk of contracting AIDS is by revelation that, in general, this type of transaction occurs without adopting measures of safe sex, whether the effect of the drug in the body, lack of access to condoms or even, the difficulty of incorporating such information. Although the effects of drugs in the body appear as a factor that hinders the adoption of condom use, women proved not to adopt safe sex measures, independent of whether or not under the influence of drugs. For them, the non-incorporation of this preventive measure is more for personal resistances and partner[43].

Women with low socioeconomic and educational level of little significance, conditions were being infected with HIV, victims of a hegemonic thinking female invulnerability[35]. The difficulty in negotiating safe sex associated with poverty, unemployment, low income and access to goods and services[30,39], absence of strong and continuous affective ties, being expelled from the family home and school, exposure to violence, institutionalization, use drugs, crime and discrimination are female vulnerability to HIV factors[40].

Speaks of the impoverishment of the disease, to be a higher incidence of AIDS cases among the lower socioeconomic status and women generally poorer and with little significant degree of education, not having access to adequate information is dependent solely on knowledge of folk wisdom, which leads them to create fantasies and fears about their own bodies. The increase in female participation in the numbers of the epidemic brings other issues, such as lack of protection for the woman, as evidenced by limitations both in interpersonal relationships, as in the economic and social condition [24].

Marked by rooted conceptions of male and female roles, these women eventually understand certain dynamics of life as logical, correct and immutable. Thus, one can understand how certain behaviors men remain untouched, even when criticized and sometimes involved a desire to be different. In the family context, these wives understand their role as natural and desired by all other women, without question or explicit criticism, where any turbulence that arises in the relationship is seen as an expected situation[22].

From these aspects, it can be suggested that married women, especially those with little education and have low socioeconomic level tend to recognize HIV/AIDS as a distant possibility in their lives. These women often are involved in definitions and concepts that clarify and somewhat more to confuse their perception of contamination risk[24].

In view of the vulnerability, not only would the effects of poverty and economic inequality, reflected in the lack of access to goods and services, responsible for heterogeneity in morbidity and mortality profiles between different human groups. Different mechanisms of social exclusion, discrimination and oppression related to gender, ethnicity, age and mode of exercise sexuality also affect the degree of population health by facilitating the occurrence of certain conditions or inhibit access to the means to its

prevention and care[45]. The vulnerability of a group to HIV infection and disease is the result of a number of factors and characteristics that lead to contexts of political, economic and sociocultural vulnerability that expand or dilute the individual risk[46,47]. It was observed that in some studies of this review the vulnerability factors for both isolates appeared study as listed in others.

CONCLUSION

The search for studies on women's vulnerabilities to HIV/AIDS helped identifying a significant literature on the subject and concluded that the research on the interrelationship of factors that can lead to vulnerability contexts has been a major concern to students about HIV/AIDS. The factors associated with vulnerabilities presented in this review allow deepening knowledge and contribute to enable the development of further research.

It is necessary to point out some limitations of this study as abstracts with incomplete structure, articles not available in full and repetitions of the same articles in the databases after the crossing may have influenced the exclusion of articles.

The analyzed studies show that discuss the vulnerabilities of women to HIV/AIDS also implies discuss individual or group values, beliefs, sexuality, ethnicity, social, cultural, economic, risk behaviors that are leading women to be infected each again, increasing epidemic disease.

It is recommended the development of other studies on contexts of vulnerabilities of women to HIV/AIDS, since factors alone or interrelated vulnerabilities are leading to these contexts, as well as expansion and sophistication of prevention programs for these women having more access to the means for its prevention and care.

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enfermagem: subsídios para a reformulação do ensino de graduação. Rev. Saúde coletiva, 2009, 30 [6]:119-124.

Received on: 01/08/2015
Required for review: no
Approved on: 01/12/2015
Published on: 30/12/2015

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